State of Vermont, Agency of Education
School-Based Health Services
Level of Care (LOC) Billing Form

Student's Name: _____ **Medicaid ID:** _____

School District: _____ School Attending: _____

Supervisory Union: _____ Diagnostic Code: _____

IEP Initiation Date: _____ _____ Date of Birth: _____

Period Billed: From Date of Service: _____ Case Manager: _____

To Date of Service: _____

The number of school days for this billing period was: _____ which equals 0.0 weeks for the period.

Provider Type	Group Size	Medicaid Service Category	Developmental & Assistive Therapy Description	Hours Provided for the Billing Period	Billable Hours Per Week	Conversion Factor			Units	Hours Per Week (from IEP)	Monthly Hours (from IEP)
Professional	1:1	Case Management				x	3	=			
						x		=			
						x		=			
						x		=			
						x		=			
						x		=			
						x		=			
						x		=			
						x		=			
						x		=			
						x		=			
						x		=			
						x		=			
						x		=			
						x		=			
						x		=			
						x		=			
						x		=			

LOC Assignment:

LOC	Units Per Week
1	5.99 or less
2	6 to 11.99
3	12 to 23.99
4	24 or More

Enter Total Units Per Week in Excess Of 42

Total Units Per Week 0.00

LOC 0

Outliers

Notes (for case management only claims, indicate the other entity that is billing IEP services to Medicaid and the IEP service being billed):

_____

_____

I verify that the above services match the information on the attached documentation log(s), are required by the student's IEP, are certified as medically necessary and meet all other billing requirements.

Medicaid Clerk's Signature: _____ Date: ____/____/____

Payment information:

Submit Date: _____/_____/_____ RA Date: _____/_____/_____